This Information Should Be Directed to the Management Staff of Your Agency

Bureau Talk

Missouri Department of Health
Bureau of Home Care and Rehabilitative Standards
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Criminal Background Checks – EDL Checks & Criminal Disclosure Statements

Criminal background checks, EDL checks, and criminal disclosure statements have recently become the subject of deficiencies written during survey activity. Please remember this is not a Medicare regulation, it is not a Bureau regulation, it is a State law and everyone must be responsible for implementation. However, deficiencies can be written under both home health and hospice regulations which refer to being in compliance with all State and Federal laws. Below is a copy of the law as found at 660.317 RSMo.

If you have an employee that has been in your corporate system for years and years and that employee is hired and/or transferred to your agency, the checks must be done as they would be on any other new hire. Keep in mind that your agency is separately licensed and separately certified, thus separate from your corporate system. However, if that employee has worked within that system and the appropriate checks were done at time of hire, simply obtain copies for your personnel file.

660.317. Criminal background checks of employees, required when – persons with criminal history not to be hired, when, penalty – failure to disclose, penalty – definitions – rules to waive hiring restrictions. –

1. For the purposes of this section, the term **"provider"** means any person, corporation or association who:
   (1) Is licensed as an operator pursuant to chapter 198 RSMo:
   (2) Provides in-home services under contract with the department;
   (3) Employs nurses or nursing assistants for temporary or intermittent placement in health care facilities; or
   (4) Is an entity licensed pursuant to chapter 197, RSMo;
   (5) Is a public or private facility, day program, residential facility or specialized service operated, funded or licensed by the department of mental health.
2. For the purpose of this section **"patient or resident"** has the same meaning as such term is defined in section 43.540, RSMo.
3. Beginning August 28, 1997, not later than two working days of hiring any person for a full-time, part-time or temporary position to have contact with any patient or resident the provider shall, or in the case of temporary employees hired through an employment agency, the employment agency shall prior to sending a temporary employee to a provider;
   (1) Request a criminal background check as provided in section 43.540, RSMo. Completion of an inquiry to the highway patrol for criminal records that are available for disclosure to a provider for the purpose of conducting an employee criminal records background check shall be deemed to fulfill the provider's duty to conduct employee criminal background checks pursuant to this section; except that, completing the inquiries pursuant to this subsection shall not be construed to exempt a provider from further inquiry pursuant to common law requirements governing due diligence; and
   (2) Make an inquiry to the department of social services, whether the person is listed on the employee disqualification list as provided in section 660.315.
4. When the provider requests a criminal background check pursuant to section 43.530, RSMo, the requesting entity may require that the applicant reimburse the provider for the cost of such record check.
5. An applicant for a position to have contact with patients or residents of a provider shall:
   (1) Sign a consent form as required by section 43.540, RSMo, so the provider may request a criminal records review;
   (2) Disclose the applicant's criminal history. For the purposes of this subdivision **"criminal history"** includes any conviction or a plea of guilty to a misdemeanor or felony charge and shall include any suspended imposition of sentence, any suspended execution of sentence or any period of probation or parole; and
   (3) Disclose if the applicant is listed on the employee disqualification list as provided in section 660.315.
6. An applicant who knowingly fails to disclose his criminal history as required in subsection 5 of this section is guilty of a class A misdemeanor. A provider is guilty of a class A misdemeanor if the provider knowingly hires a person to have contact with patients or residents and the person has been convicted of, pled guilty to or nolo contendere in this state or any other state or has been found guilty of a crime, which if committed in Missouri would be a class A or B felony violation of chapter 565, 566, or 569, RSMo, or any violation of subsection 3 of section 198.070, RSMo, or section 568.020, RSMo.
7. The highway patrol shall examine whether protocols can be developed to allow a provider to request a statewide fingerprint criminal records review check through local law enforcement agencies.
8. A provider may use a private investigatory agency rather than the highway patrol to do a criminal history records review check, and alternatively, the applicant pays the private investigatory agency such fees as the provider and such agency shall agree.
9. The department of social services shall promulgate rules and regulations to waive the hiring restrictions pursuant to this section for good cause. For purposes of this section, **"good cause"** means the department has made a determination by examining the employee's prior work history and other relevant factors that such employee does not present a risk to the health or safety of residents.

(L. 1996 H.B. 1362, A.L. 1997 S.B. 358, A.L. 1998 H.B. 1046 and H.B. 1907

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OASIS Update

The Bureau is currently writing deficiencies related to collecting, encoding and transmitting OASIS data. The survey staff also may be reviewing agency policies regarding the OASIS process. Please note G-tag 342, Standard 484.55(e) in the Conditions of Participation, which refers to "Incorporation of OASIS Data Items." This standard directs the OASIS data items MUST be incorporated into the HHA's own assessment and must include those items listed. The surveyors will be looking for a combined, merged, blended, united, etc. (whatever definition of incorporated you choose) assessment. There has been a lot of teaching during the survey process in regard to OASIS and remember Bonnie Quick is available in our office for guidance and to answer specific OASIS questions. A list of frequently asked questions is provided below for your quick reference.

Currently ***OASIS information CANNOT be faxed nor sent through the internet*** from a branch office to its parent office. HCFA realizes patient information is faxed for other purposes, but for now OASIS information cannot be faxed. This is a problem encountered during survey activity, especially for branch offices of out-of-state providers. Deficiencies will be cited regarding patient confidentiality.

Question 1:
Would an OASIS data set be completed on a 22-year old female who is receiving home care because she has an infected c-section incision?

Answer 1:
A 22-year old female who is a post-partum patient (i.e., treatment is provided for conditions related to pregnancy and/or childbirth) would be excluded from the OASIS collection requirement.

Question 2:
How do the OASIS regulations apply to Medicaid HHA programs? Do the OASIS regulations apply to HHAs operating under Medicaid waiver programs?

Answer 2:
The OASIS regulations apply to all patients of an HHA that must meet the home health Medicare Conditions of Participation. Under current Medicare requirements, an initial evaluation of a patient must be conducted by an HHA. This requirement is expanded in the new OASIS regulations to require that in addition to an initial evaluation the agency must also conduct a comprehensive assessment of a patient that includes certain data items, i.e., those in the OASIS data set. An agency that currently must meet the Medicare conditions under Federal and/or State law will need to meet the OASIS Conditions of Participation.

If an HHA operates under a Medicaid waiver, and in that State it is required by State law that HHAs must meet the Medicare conditions of participation in order to operate under the Medicaid waiver, then OASIS applies. If an HHA operates under a Medicaid waiver, and in that State it is not required under State law that the HHA must meet the Medicare conditions of participation in order to operate under the Medicaid waiver, then OASIS does not apply. HHAs should check with their Medicaid programs.

Question 3:
We are a HHA that also provides hospice services. Do the OASIS requirements apply to our hospice patient population? What if they are receiving "hospice service" under the home care agency (not the Medicare hospice benefit)? Would OASIS apply?

Answer 3:
HHA Conditions of Participation are separate from the rules governing the Medicare hospice program. Care being delivered to a

Answer 3 Continued:
patient under the Medicare home health benefit needs to meet the Federal requirements put forth for home health agencies which includes OASIS data collection and reporting. Care being delivered to a patient under the Medicare hospice benefit needs to meet the Federal requirements put forth for hospice care. These requirements do not include OASIS data collection or reporting. However, if a patient is receiving terminal care services through the home health benefit, OASIS applies.

Question 4:
Does the OASIS data need to be incorporated into the agencies comprehensive assessment?

Answer 4:
Yes, it should be incorporated as opposed to "tacking" it on to the agency assessment. Discussion of this can be found in the Federal Register in the preamble to the comprehensive assessment regulation on page 3771 and 3772. Information can also be found in the OASIS User Manual page 7.2 regarding integration of OASIS items into clinical documentation. A standard level deficiency could be cited at G342 for failure to incorporate OASIS data.

Question 5:
In reference to MO170 which states, "From which of the following Inpatient Facilities was the patient discharged during the past 14 days?" What would a Skilled Nursing Facility (SNF) unit in a hospital be considered since a SNF unit has it's own provider number?

Answer 5:
Number 4 would be selected - other - and then specify that it was a SNF unit.

Question 6:
If a patient goes into the hospital via the emergency room and they are admitted to the hospital from the ER, is the ER visit considered the beginning of their transfer to the inpatient facility or is this a separate incident?

Answer 6:
While in the ER, a patient is still officially a patient of the home health agency. The transfer date would then be the date the patient was actually admitted to the hospital. ■

Changes in Agencies

Any change in the status of your agency needs to be reported to our Bureau. Some examples include expansion or reduction of service area, addition of branch offices, and changes in administrative personnel. Some changes require prior approval from both the Federal and State officials. ***All requests for changes must be submitted in writing.*** *This must be a separate request and not just a note included on the license renewal application. Changes cannot be implemented until all the required documents have been completed, the Bureau has notified HCFA of the change, and notification of approval is received by the agency.*

Advance Beneficiary Notices (ABN)

HCFA issued a program memorandum, Transmittal No. A-99-52, in December, 1999, which provides instructions to all HHAs regarding their responsibility to issue notices to Medicare beneficiaries in advance of furnishing what HHAs believe to be non-covered care, or of reducing or terminating ongoing care. This new HHA responsibility is part of the HHA Conditions of Participation at 42 CFR 484.10 and applies to Medicare beneficiaries covered under Part A and Part B.

HHAs may replicate the model home health advance beneficiary notices HCFA provided in the transmittal or may design their own. If your agency designs its own ABN, you must follow the guidelines concerning clarity and accuracy contained in the program memorandum. The ABN should ensure that beneficiaries receive timely, accurate, complete and useful information which will enable them to make informed consumer decisions, with a proper understanding of their financial liability, their rights to a Medicare initial determination, their appeal rights in the case of payment denial, and how these rights are waived if they refuse to allow their medical information to be sent to Medicare. These notices apply where a physician has ordered home health care for a beneficiary but the HHA believes that Medicare will not pay for that care. They do not apply to situations where the physician will not order care, or where care is reduced or terminated in accordance with a physician's order.

If the HHA expects payment for the home health services to be denied by Medicare, a beneficiary must be advised before home health care is initiated or continued, that in the HHA's opinion, payment probably will be required from him/her personally. These notices must be issued by the HHA each time, and as soon as the HHA makes the assessment that it believes Medicare payment will not be made. These notices should be hand-delivered to the beneficiary; a telephone notice must be followed-up immediately with a mailed notice or a personal visit at which written notice is delivered in person. The HHA must obtain the signed notice from the Medicare beneficiary, either in person, or where this is not possible, via return mail from the beneficiary as soon as possible after it is signed. The HHA must return a copy of the notice, including the date of the HHA's receipt, within 30 calendar days to the beneficiary. The HHA must maintain a copy of the signed ABN. If the beneficiary chooses to be financially liable for the home health services provided if Medicare does not pay and requests that a claim be submitted to Medicare, the HHA must submit a demand bill and provide the beneficiary with a copy of the claim or a written statement that the HHA has submitted the claim and the date submitted.

In summary, these notices must be provided by HHAs in accordance with the program memorandum and in any case where a reduction or termination of services is to occur, or where services are to be denied before being initiated, except in any case in which a physician concurs in the reduction, termination, or denial of services. Failure to do so is a violation of the HHA conditions of participation in requirements at 42 CFR 484.10(c) Patient Rights: Standard: Right to be informed and to participate in planning care and treatment and at 42 CFR 484.10 (e) Patient Rights: Standard: Patient liability for payment. Our bureau has received a directive from HCFA that compliance with the Medicare ABN will be monitored during the survey process. We will: 1) need to see copies of the notices your agency gives to beneficiaries, 2) review any records of Medicare patients who have had their services involuntarily reduced or terminated by the agency, 3) review the relevant HHA policies and procedures, and 4) review the complaint log for any allegations of non-compliance with the HHA's requirement to provide proper notice. ■

Do Not Resuscitate Orders, CPR, Advance Directives, Etc.

Any Medicaid or Medicare certified and/or participating provider which operates under a policy or procedure which denies resuscitation to all patients is in violation of the Medicare residents rights and/or quality of care requirements per HFCA. This statement of policy applies to all providers which are required to adhere to the advance directives requirements found at 42 CFR 489.102(a), i.e., hospitals, rural primary care hospitals, skilled nursing facilities, nursing facilities, home health agencies, hospices, providers of home health care, and providers of personal care services (for Medicaid purposes).

HCFA strongly encourages providers to develop policies dealing with situations where resuscitation may be called for. Provider staff clearly need such policies in order to perform effectively in these situations where patient self-determination, family wishes, staff's personal and professional ethics and legal requirements can come into conflict. While HCFA encourages provider development of policies in this area, HCFA does not permit policies which allow the provider the right to deny resuscitation to all patients in all situations.

Section 4206(a) of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) amended section 18665(a)(1) of the Social Security Act. The amendment added a new subparagraph (Q); which specifies that to participate in the Medicare program, hospitals, skilled nursing facilities, home health agencies, and hospice providers must comply with the Advance Directive requirements found in Sections 1866(f).

According to that section and the regulations, an advance directive means "written instructions, such as a living will or durable power of attorney for health care, recognized under state law, relating to the provision of health care when the individual is incapacitated." This also includes "do not resuscitate" (DNR) orders. A living will generally states the kind of medical care that an individual wants, or does not want, if he or she is unable to make his or her own decision. A durable power of attorney for health care is a signed, dated, and witnessed statement naming another person to act for the individual in making medical decisions for that individual should they become unable to make those decisions for himself or herself.

Therefore, it is important to have your care staff skilled in CPR to be able to resuscitate a patient who wants resuscitation. For hospice volunteers, HCFA feels that CPR should be taught to any volunteer who desires the training. Keep in mind,

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no policy can state the agency will not do CPR. HCFA received inquiries about whether a provider's reliance on "911" is a violation of Medicare requirements. The answer, in most circumstances, is "Yes, relying on '911' in lieu of staff to provide resuscitation is a violation." The general rule is that a provider must act in order to prevent injury to its patients. Circumstances requiring a call to "911" would also require the provider to take other immediate and reasonable steps to revive the patient in order to avoid injury to that patient. ■

Advance Directives Information

Condition of Participation 484.10(c)(2)

PART I

489.102(a) Each agency/hospice must have policies and procedures that address Advance Directives. These must include:

(1) (i) Information about Durable Power of Attorney, Living Will and Case Law.

(1) (ii) Policy of agency respecting the implementation of such rights, including a clear and precise statement of limitation if the provider cannot implement an advance directive on the basis of conscience.

(3) Must not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive.

PART II

489.102(a)(1) The following must be given to the patient in writing in advance of an individual coming under the care of an agency/hospice (A notation in the clinical record that this was done would be appropriate – we will confirm this activity during home visits):

(ii) Agency policy on advance directives including, at least, the preceeding information (in Part I).

(i) Description of patients rights under state law. (See enclosed sample brochure).

(i) Patients right to accept or refuse medical or surgical treatment.

(i) Patients right to formulate an advance directive.

489.102(a)(2) Documentation must be present in the individuals medical record whether or not the individual has executed an advance directive.

489.102(5) Provide for education of staff.

489.102(6) Provide for community education.

(From Federal Register Volume 57, No. 45, Friday, March 6, 1992, Pg. 8203)

Missouri Branch Offices of Out-of-State Providers

Out-of-state home health and hospice providers serving Missouri patients are required by state law to apply for licensure and establish a branch office in Missouri. All information/correspondence, including survey documents, will be mailed to the parent entity holding the state license. It will then be the responsibility of the license holder (parent) to ensure proper distribution of the information/correspondence to their branch office. As part of the survey activity at the branch office, the surveyor(s) will require a copy of the current Medicare certification survey in order to check for compliance with the Medicare requirements. Don't forget – Missouri has some specific state laws, i.e. criminal background checks, advance directive information, etc. that will also be reviewed. ■

Outpatient Physical Therapy Services (OPTs)

42 CFR 405.1720 requires the rehabilitation agency to provide social or vocational adjustment services to all patients in need of such services. The agency's qualified staff must evaluate the social or vocational factors involved in a patient's rehabilitation program, counsel and advise on social or vocational problems due to the patient's injury or illness, and make appropriate referrals for required services. A "yes" or "no" question asked of the patient on admission regarding the need for such services does not meet this requirement. Documentation must be provided by a physician, qualified psychologist, social worker, or vocational specialist. ■

Clarification of Home Health Agency Interpretive Guideline Tag G161

This regulation requires orders for therapy services to include the specific procedures and modalities to be used and the amount, frequency and duration of the therapy ordered. HCFA defined "modalities" as any physical agent applied to produce therapeutic changes to biologic tissue and include, but are not limited to, thermal, acoustic, light, mechanical, or electric energy. "Procedures" are defined as a manner of effecting change through theapplication of clinical skills and/or services that attempt to improve function. This can be achieved through exercise or training and must include active interaction between therapist and beneficiary.

Modalities that are supervised but do not require constant patient contact (by the provider) include hot or cold packs, traction, mechanical or electrical stimulation (unattended) acupuncture with electrical stimulation, vasopneumatic devices, paraffin bath, microwave, whirlpool, diathermy, infrared and ultraviolet. Modalities requiring constant attendance include electrical stimulation (manual) iontophoresis, contrast baths, ultrasound and Hubbard tank. Items such as Theraband, free weights and stationary bikes are not considered modalities. They are considered equipment or items used in support of a procedure such as therapeutic exercise or neuromuscular re-education. ■